EPO VALUE

TUFTS Health Plan

SUMMARY OF BENEFITS

With this Exclusive Provider Option (EPO) plan administered by Tufts Health Plan, you enjoy comprehensive coverage for your health care needs while your out-of-pocket costs are kept to a minimum. The following benefits apply when care is medically necessary and provided or authorized by your Tufts Health Plan primary care physician.

Outpatient Medical Care*	
Doctor's Office Visits	$15 per visit
Routine Physical Exams	$15 per visit
Well-Child Care	$15 per visit
Specialist Care, Consultations	$15 per visit
OB/GYN visits	$15 per visit
Prenatal and Postnatal Care	$15 per visit
Laboratory Tests, including Pap Smear	Covered in Full
Diagnostic X-rays, including Mammograms	Covered in Full
Injections and Immunizations	Covered in Full
X-ray Therapy	Covered in Full
Speech Therapay and Short-term Physical/Occupational Therapy	$15 per visit
Annual Routine Eye Exams	$15 per visit
Spinal Manipulation (12 visits per calendar year)	$15 per visit

Inpatient Hospital Care and Surgery**	
Day Surgery	$0 per surgery
Acute care for Illness or Injury, and Maternity Services	$150 per admission
Physician's Care while hospitalized	Covered in Full
Surgery and Surgeon's Services while hospitalized	Covered in Full
Newborn Care in hospital	Covered in Full
Anesthesia while hospitalized	Covered in Full
Medications while hospitalized	Covered in Full
Nursing Care while hospitalized	Covered in Full
X-ray and Lab Services while hospitalized	Covered in Full
Intensive Care/Coronary Care while hospitalized	Covered in Full
Radiation Therapy while hospitalized	Covered in Full
Skilled Nursing In Skilled Nursing Facility (up to 100 days per calendar year)	Covered in Full

Wellness Programs	
Membership at Network Fitness Facilities	Multiple discount options
Weight Watchers Weight Management Program	Discounted membership
Health Education (may require advance payment)	30% discount per program

* No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams or mammograms.

** Semi-private room, unless private room is medically necessary.

(OVER)

EPO Value - Summary of Benefits

Mental Health*	
Outpatient Care (up to 30 visits per calendar year)	$15 per visit
Inpatient Care (Services provided through a Designated Facility Program for up to 60 days per calendar year)	$150 per admission

Substance Abuse**	
Outpatient Care (Alcohol, Drug and Detoxification) (Covered up to $500 per calendar year)	$15 per visit
Inpatient Care (Services provided through a Designated Facility Program for up to 30 days per calendar year)	$150 per admission

Emergency Care	
In Doctor's Office	$15 per visit
In Emergency Room	$50 per visit

Other Services	
Durable Medical Equipment ($5,000 calendar year maximum)	Plan pays 80%; Member pays 20%
Ambulance (when medically necessary)	Covered in Full
Pediatric Dental X-Rays, full mouth once every 5 years. Bitewings, once every 6 months and periapicals as needed. Periodic oral exam, oral prophylaxis and fluoride treatment once every 6 months.	Covered for children under 12

Inpatient Out-of-Pocket Maximum	
Annual Indivicual Out-of-Pocket Maximum	$300
Annual Family Out-of-Pocket Maximum***	$300

* As required by law, coverage for certain mental health disorders is the same as for other medical conditions. See your member benefit document for more information.

** Treatment for detoxification is not subject to substance abuse day and visit limits listed in this document. See your member benefit document for more information.

*** No more than two inpatient copayments will apply to each family. Maximums will be administered by City of Newton.

There are some services that the plan does not cover. These include, but are not limited to: A service or supply not described as covered in the member's benefit document • Exams required by a third party, such as your employer, an insurance company, school or court • Any tax, surcharge, assessment or other similar fee imposed under any state or federal law or regulation on any provider, member, service, supply or medication • Cosmetic surgery or any other cosmetic procedure except certain reconstructive procedures • Experimental or investigational drugs, services and procedures • Eyeglasses or contact lenses • Whole blood, packed red blood cells and blood donor fees • Drugs for use outside of hospital except as covered under Prescription Drug Coverage • Personal comfort items • Custodial care • A service furnished to someone other than the member • Routine foot care • Charges incurred for stays in a covered facility beyond the discharge hour • Care for conditions that state or local law requires to be treated in public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Long-term (more than 60 days) outpatient physical and occupational therapy services • Foot orthotics • Assisted reproductive technology (e.g. IVF) procedures for non-Massachusetts residents

This is a summary only. Please refer to your member benefit document for more detailed information.

Copies are available through your employer.